

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div><div>I. IDPH Facility ID Number: 0007435</div><div>Facility Name: CENTRAL BAPTIST HOME</div><div>Address: 4747 N. CANFIELD AVE NORRIDGE 60706 Number City Zip Code</div><div>County: COOK</div><div>Telephone Number: (708) 452-3711 Fax # (708) 452-3840</div><div>IDPA ID Number: 361952520002</div><div>Date of Initial License for Current Owners: 11/01/78</div><div>Type of Ownership:<div><div><div><div>X</div><div>VOLUNTARY,NON-PROFIT</div></div><div><div>X</div><div>Charitable Corp.</div></div><div><div></div><div>Trust</div></div><div>IRS Exemption Code 501(C)(3)</div></div><div><div><div></div><div>PROPRIETARY</div></div><div><div></div><div>Individual</div></div><div><div></div><div>Partnership</div></div><div><div></div><div>Corporation</div></div><div><div></div><div>"Sub-S" Corp.</div></div><div><div></div><div>Limited Liability Co.</div></div><div><div></div><div>Trust</div></div><div><div></div><div>Other</div></div></div><div><div><div></div><div>GOVERNMENTAL</div></div><div><div></div><div>State</div></div><div><div></div><div>County</div></div><div><div></div><div>Other</div></div></div></div></div><div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div><div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div><div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div><div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div><div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div></div><div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) EDWARD N. SLACK, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax# (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div></div>
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Facility Name & ID Number CENTRAL BAPTIST HOME

0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>124</u>	Skilled (SNF)	<u>124</u>	<u>45,260</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,585</u>	5
6		ICF/DD 16 or Less			6
7	<u>153</u>	TOTALS	<u>153</u>	<u>55,845</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,577</u>	<u>9,648</u>	<u>1,236</u>	<u>14,461</u>	8
9	SNF/PED					9
10	ICF	<u>13,009</u>	<u>11,613</u>		<u>24,622</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,586</u>	<u>21,261</u>	<u>1,236</u>	<u>39,083</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.98%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 11/01/1978

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/01/1978 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 1236

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	594,095	35,293	26,500	655,888		655,888	(160,427)	495,461			1
2	Food Purchase		349,117		349,117		349,117	(145,253)	203,864			2
3	Housekeeping	196,249	53,456	80,887	330,592		330,592	(113,631)	216,961			3
4	Laundry	73,749	8,938	33,626	116,313		116,313	(49,812)	66,501			4
5	Heat and Other Utilities			227,843	227,843		227,843	(78,314)	149,529			5
6	Maintenance	192,457	37,326	191,891	421,674		421,674	(144,937)	276,737			6
7	Other (specify):*											7
8	TOTAL General Services	1,056,550	484,130	560,747	2,101,427		2,101,427	(692,374)	1,409,053			8
	B. Health Care and Programs											
9	Medical Director			26,400	26,400		26,400		26,400			9
10	Nursing and Medical Records	1,645,994	58,441	1,680	1,706,115		1,706,115		1,706,115			10
10a	Therapy	48,016		613	48,629		48,629		48,629			10a
11	Activities	252,231	30,332	756	283,319		283,319	(122,580)	160,739			11
12	Social Services	152,127	5,746	2,160	160,033		160,033	(68,536)	91,497			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,098,368	94,519	31,609	2,224,496		2,224,496	(191,116)	2,033,380			16
	C. General Administration											
17	Administrative	156,828			156,828		156,828		156,828			17
18	Directors Fees											18
19	Professional Services			110,312	110,312		110,312	(48,540)	61,772			19
20	Dues, Fees, Subscriptions & Promotions			89,072	89,072		89,072	(66,263)	22,809			20
21	Clerical & General Office Expenses	324,250	30,256	141,258	495,764		495,764	(271,089)	224,675			21
22	Employee Benefits & Payroll Taxes			898,986	898,986		898,986	(145,066)	753,920			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,462	8,462		8,462	(8,462)				24
25	Other Admin. Staff Transportation			1,190	1,190		1,190		1,190			25
26	Insurance-Prop.Liab.Malpractice			114,028	114,028		114,028	(39,194)	74,834			26
27	Other (specify):*											27
28	TOTAL General Administration	481,078	30,256	1,363,308	1,874,642		1,874,642	(578,614)	1,296,028			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,635,996	608,905	1,955,664	6,200,565		6,200,565	(1,462,104)	4,738,461			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			766,769	766,769		766,769	(251,301)	515,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			581,597	581,597		581,597	(581,597)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,911	1,911		1,911		1,911			35
36	Other (specify):*			25,260	25,260		25,260		25,260			36
37	TOTAL Ownership			1,375,537	1,375,537		1,375,537	(832,898)	542,639			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,165	76,809	115,974		115,974		115,974			39
40	Barber and Beauty Shops		1,084		1,084		1,084	(1,084)				40
41	Coffee and Gift Shops		41,249		41,249		41,249	(34,852)	6,397			41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*	221,902	6,255	183,723	411,880		411,880	(411,880)				43
44	TOTAL Special Cost Centers	221,902	87,753	328,422	638,077		638,077	(447,816)	190,261			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,857,898	696,658	3,659,623	8,214,179		8,214,179	(2,742,818)	5,471,361			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,182	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,439)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,718,761)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,742,818)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,742,818)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS			Page 5A
CENTRAL BAPTIST HOME			
ID# 0007435			
Report Period Beginning: 01/01/01			
Ending: 12/31/01			
Sch. V Line			
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1 Public Relations	(8,168)	20	1
2 Bank Charges	(8,640)	21	2
3 Investment Expense	(26,867)	21	3
4 Meals on Wheels	(43,979)	2	4
5 Independent Living Allocations	(60,427)	1	5
6 Independent Living Allocations	(102,174)	2	6
7 Independent Living Allocations	(113,631)	3	7
8 Independent Living Allocations	(49,812)	4	8
9 Independent Living Allocations	(76,314)	5	9
10 Independent Living Allocations	(144,937)	6	10
11 Independent Living Allocations	(121,334)	11	11
12 Independent Living Allocations	(68,530)	12	12
13 Independent Living Allocations	(46,370)	19	13
14 Independent Living Allocations	(17,684)	20	14
15 Independent Living Allocations	(68,282)	21	15
16 Independent Living Allocations	(145,060)	22	16
17 Independent Living Allocations	(39,194)	26	17
18 Marketing Expenses	(130,290)	43	18
19 Independent Living Expenses	(156,415)	43	19
20 Investment Expenses	(96,587)	43	20
21 Newsletter	(30,538)	43	21
22 Development Expenses	(50)	43	22
23 Endowment and Assistance Expense	(37,172)	20	23
24 Gift Shop Sales	(270)	41	24
25 Telephone Revenue	(28,532)	21	25
26 Non-Care Depreciation	(255,483)	30	26
27 Ice Cream Shop Sales	(14,562)	41	27
28 Beauty Shop Income	(1,084)	40	28
29 Chapel Fund Receipts	(2,911)	21	29
30 Late Fee Revenue	(11,207)	21	30
31 Unsubstantiated Travel	-2427	24	31
32 Holiday Bazaar Income	-1246	11	32
33 Non-Care Interest	-581597	32	33
34 Seminar Expense	-6035	24	34
35 Unsupported Legal Fees	-2270	19	35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
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90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
Total	(2,718,761)		

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435

Report Period Beginning:

01/01/01

Ending:

12/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(160,427)											(160,427)	1
2	Food Purchase	(145,253)											(145,253)	2
3	Housekeeping	(113,631)											(113,631)	3
4	Laundry	(49,812)											(49,812)	4
5	Heat and Other Utilities	(78,314)											(78,314)	5
6	Maintenance	(144,937)											(144,937)	6
7	Other (specify):*													7
8	TOTAL General Services	(692,374)											(692,374)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(122,580)											(122,580)	11
12	Social Services	(68,536)											(68,536)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(191,116)											(191,116)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(48,540)											(48,540)	19
20	Fees, Subscriptions & Promotions	(66,263)											(66,263)	20
21	Clerical & General Office Expenses	(271,089)											(271,089)	21
22	Employee Benefits & Payroll Taxes	(145,066)											(145,066)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(8,462)											(8,462)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(39,194)											(39,194)	26
27	Other (specify):*													27
28	TOTAL General Administration	(578,614)											(578,614)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,462,104)											(1,462,104)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
30	Depreciation	(251,301)											(251,301) 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(581,597)											(581,597) 32
33	Real Estate Taxes												33
34	Rent-Facility & Grounds												34
35	Rent-Equipment & Vehicles												35
36	Other (specify):*												36
37	TOTAL Ownership	(832,898)											(832,898) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops	(1,084)											(1,084) 40
41	Coffee and Gift Shops	(34,852)											(34,852) 41
42	Provider Participation Fee												42
43	Other (specify):*	(411,880)											(411,880) 43
44	TOTAL Special Cost Centers	(447,816)											(447,816) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,742,818)											(2,742,818) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:	
Schedule V			Line	Item		Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V					\$				\$	
2	V										
3	V										
4	V										
5	V										
6	V										
7	V										
8	V										
9	V										
10	V										
11	V										
12	V										
13	V										
14	Total				\$				\$	\$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Schedule N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____) _____
Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

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A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Street Address
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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CENTRAL BAPTIST HOME # 0007435 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
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()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	1999 A Bond Series		X	Assisted Living Construction		11/01/99	\$ 10,000,000	\$ 10,000,000	11/15/29	5.5-7.13%	\$ 348,958	1	
2	1999 B Bond Series		X	Assisted Living Construction		11/01/99	13,300,000	13,300,000	11/15/29	3.63%	232,639	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 23,300,000	\$ 23,300,000			\$ 581,597	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11												11	
12	Non-Care Interest										(581,597)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (581,597)	14	
15	TOTALS (line 9+line14)						\$ 23,300,000	\$ 23,300,000			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)
** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

CENTRAL BAPTIST HOME

0007435

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$		\$			\$	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

CENTRAL BAPTIST HOME

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0007435

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A.

Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1. N/A		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B.

Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C.

Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,531

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Retirement Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1956, 2000</u>	<u>\$ 78,131</u>	<u>1</u>
2	<u>Facility</u>		<u>2001</u>	<u>206,254</u>	<u>2</u>
3	TOTALS			<u>\$ 284,385</u>	<u>3</u>

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152			1984	\$ 1,700,300	\$	35	\$ 48,580	\$ 48,580	\$ 829,908	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	741,182		20	18,530	18,530	429,269	9
10	Various			1981	7,776		20	199	199	4,645	10
11	Various			1982	43,242		20	1,585	1,585	32,408	11
12	Various			1983	121,447		20	2,665	(2,665)	117,449	12
13	Various			1984	21,042		20	656	656	19,247	13
14	Various			1985	6,955		20	-		6,955	14
15	Various			1986	2,614		20	-		2,614	15
16	Various			1988	15,124		20	-		15,124	16
17	Various			1989	896,232		20	29,157	29,157	373,835	17
18	Various			1990	2,017,044		20	67,032	67,032	800,224	18
19	Various			1991	59,956		20	2,567	2,567	31,277	19
20	Various			1992	201,338		20	11,643	11,643	111,215	20
21	Various			1993	134,547		20	7,872	7,872	71,115	21
22	Various			1994	107,010		20	10,130	10,130	82,114	22
23	Various			1995	292,495		20	21,384	21,384	135,898	23
24	Various			1996	17,999		20	1,747	1,747	9,778	24
25	Various			1997	74,429		20	7,946	7,946	34,548	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	-	-		-		-	68
69	Financial Statement Depreciation		511,286			(511,286)		69
70	TOTAL (lines 4 thru 69)	\$ 6,460,732	\$ 511,286		\$ 231,693	\$ (284,923)	\$ 3,107,623	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL BAPTIST HOME

0007435

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,460,732	\$ 511,286		\$ 231,693	\$ (279,593)	\$ 3,107,623	1
2	<u>1 CARPET</u>	1998	31,383		20	3,138	3,138	11,768	2
3	<u>1 DOOR & FRAME</u>	1998	1,700		20	85	85	305	3
4	<u>1 FIRE DAMPER EX FAN</u>	1998	32,115		20	1,606	1,606	5,086	4
5	<u>1 DOCK STAIRS/RAILIN</u>	1998	3,090		20	309	309	979	5
6	<u>1 CEILING TILE</u>	1998	528		20	26	26	80	6
7	<u>1 NP ELECTRICAL UPGR</u>	1998	2,758		20	138	138	425	7
8	<u>1 RES. ROOM RE-PAINT</u>	1998	22,345		20	1,117	1,117	3,444	8
9	<u>1 MED ROOM REMODEL</u>	1998	3,215		20	161	161	496	9
10	<u>1 ELEVATOR UPGRADES</u>	1998	11,617		20	581	581	1,791	10
11	<u>1 BD RM REDECORATE</u>	1998	2,561		20	128	128	395	11
12	<u>1 TUCKPOINTING</u>	1998	1,100		20	55	55	179	12
13	<u>1 COMPRESSOR</u>	1998	2,100		20	105	105	350	13
14	<u>1 FIRE ALARM SYSTEM</u>	1998	5,065		20	253	253	780	14
15	<u>1 SPRINKLER</u>	1998	2,275		20	114	114	380	15
16	<u>1 PUMP</u>	1998	566		20	57	57	180	16
17	<u>STORM WINDOWS</u>	1998	28,876		20	1,444	1,444	1,444	17
18	<u>NP DINING ROOM</u>	1998	1,153,898		20	28,847	28,847	28,847	18
19	<u>DOOR EDGE GUARDS</u>	1998	3,425		20	171	171	171	19
20	<u>1 PUMP</u>	1998	2,757		20	276	276	1,058	20
21	<u>73 BLINDS</u>	1998	9,142		20	914	914	3,504	21
22	<u>1 PARKING LOT</u>	1998	20,610		20	2,061	2,061	6,870	22
23	<u>ANTENNA REPAIR</u>	1998	2,350		20	118	118	118	23
24	<u>1 ELECTRICAL REPAIRS</u>	1999	834		20	83	83	249	24
25	<u>76 TOILET SAFETY RAI</u>	1999	2,084		20	208	208	590	25
26	<u>1 PATCH PANEL</u>	1999	860		20	86	86	237	26
27	<u>1 ACCELERATOR</u>	1999	1,150		20	115	115	316	27
28	<u>2 HOT WATER TANKS</u>	1999	35,892		20	3,589	3,589	9,571	28
29	<u>1 GAS PIPE</u>	1999	2,900		20	153	153	382	29
30	<u>1 REBUILD DOORS</u>	1999	700		20	70	70	181	30
31	<u>1 NURSE CALL SYSTEM</u>	1999	59,300		20	5,930	5,930	14,331	31
32	<u>1 PBX UPGRADES</u>	1999	54,863		20	18,288	18,288	39,624	32
33	<u>NP DINING ROOM RENOV</u>	1999	339,396		20	16,970	16,970	16,970	33
34	TOTAL (lines 1 thru 33)		\$ 8,302,187	\$ 511,286		\$ 318,889	\$ (192,397)	\$ 3,258,724	34

**Improvement type must be detailed in order for the cost report to be considered complete.

#

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,612,951	\$ 511,286		\$ 356,574	\$ (154,712)	\$ 3,312,815	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 847,101	\$	\$ 134,357	\$ 134,357	10	\$ 554,626	71
72	Current Year Purchases	108,361		14,610	14,610	10	14,610	72
73	Fully Depreciated Assets	817,007				10	817,007	73
74								74
75	TOTALS	\$ 1,772,469	\$	\$ 148,967	\$ 148,967		\$ 1,386,243	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1 BUS 1987 HANDICAP	1987	\$ 35,380	\$	\$	\$	5	\$ 35,380	76
77	FACILITY	1 FORD VAN	1995	32,705				5	32,705	77
78	FACILITY	1 PICKUP TRUCK	1997	26,767		5,353	5,353	5	22,751	78
79	FACILITY	1 1999 MERCURY VAN	1998	22,868		4,574	4,574	5	14,103	79
80	TOTALS			\$ 117,720	\$	\$ 9,927	\$ 9,927		\$ 104,939	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,787,525	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 511,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 515,468	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,182	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,803,997	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NON-CARE VEHICLES - 2001	\$ 12,933	\$ 3,354	\$ 3,697	86
87	NON-CARE BUILDING - 2001	11,243,154	249,670	322,390	87
88	1 DISHWASHER - 1981	1,817		1,817	88
89	NON-CARE EQUIPMENT - 2001	19,325	1,055	18,270	89
90	FURNITURE - 1990	17,753	1,404	12,968	90
91	TOTALS	\$ 11,294,982	\$ 255,483	\$ 359,142	91

G. Construction-in-Progress

	Description	Cost	
92	Building Construction	\$ 5,366,406	92
93			93
94			94
95		\$ 5,366,406	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy: YESNO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YESNO

16. Rental Amount for movable equipment: \$1,911Description: Money Changer

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2002 \$
13. /2003 \$
14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<div>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</div> <div><input type="checkbox"/> YES</div> <div><input checked="" type="checkbox"/> NO</div> <div>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</div>	2. <u>CLASSROOM PORTION:</u>		3. <u>CLINICAL PORTION:</u>	
	IN-HOUSE PROGRAM	<input type="checkbox"/>	IN-HOUSE PROGRAM	<input type="checkbox"/>
	IN OTHER FACILITY	<input type="checkbox"/>	IN OTHER FACILITY	<input type="checkbox"/>
	COMMUNITY COLLEGE	<input type="checkbox"/>	HOURS PER AIDE	<input type="text"/>
	HOURS PER AIDE	<input type="text"/>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	30,910	\$		\$	30,910	1		
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				2,968				2,968	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39 - 03	hrs				42,931				42,931	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39 - 02	# of prescripts					35,658			35,658	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify):							3,507			3,507	13		
14	TOTAL			\$			\$	76,809	\$	39,165		\$	115,974	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 734,170	\$	1
2	Cash-Patient Deposits	44,990		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,119,447		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,047		6
7	Other Prepaid Expenses	19,755		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	30,039		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,055,448	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	33,652,064		12
13	Land			13
14	Buildings, at Historical Cost	10,151,268		14
15	Leasehold Improvements, at Historical Cost	11,354,077		15
16	Equipment, at Historical Cost	703,898		16
17	Accumulated Depreciation (book methods)	(5,233,934)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	6,150,010		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,777,383	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 58,832,831	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 263,654	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,255		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	268,935		30
31	Accrued Taxes Payable (excluding real estate taxes)	50,745		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	100,395		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,150		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	685,367		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,427,501	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	23,300,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 23,300,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 24,727,501	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 34,105,330	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 58,832,831	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 36,227,613	1
2	Restatements (describe):		2
3	Prior year income adjustments	(175,459)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 36,052,154	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,946,824)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,946,824)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 34,105,330	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CENTRAL BAPTIST HOME

0007435

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,225,316	1
2	Discounts and Allowances for all Levels	(420,333)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,804,983	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	185,949	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 185,949	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	34,852	12
13	Barber and Beauty Care	20,384	13
14	Non-Patient Meals	77,502	14
15	Telephone, Television and Radio	28,532	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,207	19
20	Radiology and X-Ray		20
21	Other Medical Services	49,570	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,047	23
	D. Non-Operating Revenue		
24	Contributions	14,090	24
25	Interest and Other Investment Income***	1,182,290	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,196,380	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	(2,133,004)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (2,133,004)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,267,355	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,101,427	31
32	Health Care	2,224,496	32
33	General Administration	1,874,642	33
	B. Capital Expense		
34	Ownership	1,375,537	34
	C. Ancillary Expense		
35	Special Cost Centers	570,187	35
36	Provider Participation Fee	67,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,214,179	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,946,824)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,946,824)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Non-Profit If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CENTRAL BAPTIST HOME# 0007435Report Period Beginning: 01/01/01Ending: 12/31/01

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,978	2,080	\$ 79,575	\$ 38.26	1
2	Assistant Director of Nursing	1,991	2,080	46,350	22.28	2
3	Registered Nurses	10,920	13,090	455,952	34.83	3
4	Licensed Practical Nurses	5,719	7,480	258,378	34.54	4
5	Nurse Aides & Orderlies	35,540	41,765	784,315	18.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,868	4,368	48,016	10.99	8
9	Activity Director	1,968	2,080	33,368	16.04	9
10	Activity Assistants	22,370	26,342	218,863	8.31	10
11	Social Service Workers	7,784	8,320	104,981	12.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	53,219	68,097	594,095	8.72	15
16	Dishwashers					16
17	Maintenance Workers	15,383	16,914	192,457	11.38	17
18	Housekeepers	20,473	23,873	196,249	8.22	18
19	Laundry	7,169	8,272	73,749	8.92	19
20	Administrator	2,024	2,080	105,086	50.52	20
21	Assistant Administrator	1,999	2,080	51,742	24.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,057	13,102	324,250	24.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,950	2,080	21,424	10.30	31
32	Other Health Care(specify)					32
33	Other(specify)	17,192	22,394	269,046	12.01	33
34	TOTAL (lines 1 - 33)	223,604	266,497	\$ 3,857,896 *	\$ 14.48	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	26,400	09-03	36
37	Medical Records Consultant	monthly	1,080	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	600	10-03	39
40	Physical Therapy Consultant	12	613	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	756	11-03	44
45	Social Service Consultant	monthly	2,160	12-03	45
46	Other(specify)				46
47	Management Fee - Canteen		26,400	01-03	47
48	Temps - Dietary	4	100	01-03	48
49	TOTAL (lines 35 - 48)	16	\$ 58,109		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Charles Newton	Administrator	0	\$ 105,086	Workers' Compensation Insurance	\$ 69,740		IDPH License Fee	\$
Dawn Zimmerman	Asst. Admin.	0	51,742	Unemployment Compensation Insurance			Advertising: Employee Recruitment	984
				FICA Taxes	272,831		Health Care Worker Background Check	
				Employee Health Insurance	480,623		(Indicate # of checks performed 47)	564
				Employee Meals	29,662		Subscriptions & Books	2,561
				Illinois Municipal Retirement Fund (IMRF)*			Dues, Fees, Licenses	36,384
				Meals & Refreshments	4,824		Independent Living Allocation	(17,684)
				Employee Drug Screening	267		Advertising and Promotion	2,439
				Misc. Employee Expenses	677		Public Relations	8,168
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Relations	4,800			
(List each licensed administrator separately.)			\$ 156,828	Christmas Expense	2,061		Less: Public Relations Expense	(8,168)
B. Administrative - Other				Semi-Variable Fringe Benefits	33,501		Non-allowable advertising	(2,439)
Description			Amount	Independent Living Allocation	(145,066)		Yellow page advertising	
			\$					
				TOTAL (agree to Schedule V,	\$ 753,920		TOTAL (agree to Sch. V,	\$ 22,809
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid		G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Frost, Ruttenberg & Rothblatt	Accounting/Consulting		\$ 59,148				Out-of-State Travel	\$
Scitor Enterprises, Inc.	Computer Support		8,400					
Infoware	Computer Support		1,423					
Schiff & Hulbert	Legal		2,665				In-State Travel	
Advantage Consulting	Billing Services		10,554					
Tectura Corporation	Payroll Training		150					
Joseph Horowitz	Legal		22,800					
SMS	Billing Services		5,174				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 110,314				(agree to Sch. V,	
							line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number CENTRAL BAPTIST HOME

0007435

Report Period Beginning:

01/01/01

Ending:

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$7,108
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,282 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,890
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 29,662 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 77,502
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees